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THE LONDON LETTER

Reviewing the Doctor's Pay

A Royal Commission on the remuneration of N.H.S. doctors reported in 1960 and awarded substantial sums of back pay and a new scale of remuneration on condition that the profession accepted a package deal, which included agreement that future rates would be negotiated on the advice of a Review Body of independent persons to be named by the government and not to include any doctors. The idea was that the Body would review pay from time to time and recommend increases (if deemed necessary) to the government, who then would be free to reject this advice but would probably accept it. The doctors were denied access to the review body, though the Ministry of Health graciously consented to forward any representations from the profession to the Body. All this caused a certain amount of doubt in the minds of the doctors, and in recent months there have been demands from the medical press to get on with the job of at least naming the Body. In January, Lord Kindersley, who is a bank and company director and has done good work in fund-raising for the Royal College of Surgeons, was named as Chairman of the Body, and presumably the other six names will soon be forthcoming. They are to be "persons of eminence and experience", and they are to advise the Prime Minister about the remuneration of doctors and dentists, taking into account the earnings trends in other professions and the quantity and quality of recruitment in all professions. As a Council member of the B.M.A. remarked: "We are to be placed on a rung of the ladder in the hierarchy of a planned society, and may be moved up and down as the planners think the needs of the community require." Time will show whether this is a good thing or not.

Smallpox in England

For some weeks there has been a smallpox epidemic in Karachi, Pakistan, and during December five infected persons arrived at London Airport at various times and spread the infection around a wide area of Britain, including Yorkshire, South Wales and London. Up to the time of writing there have been 20 cases and eight persons have died, and the population has been shaken out of its immunizational torpor to the extent of swamping public health authorities with demands for vaccination and using up all the available supplies of lymph. There seems to have been quite a panic on for phlegmatic old England, and small wonder, for the vaccination rate is about 40% in late years and the number of revaccinations negligible, except in those who have to travel abroad and need certificates for entry into such countries as Canada and the U.S.A. Inevitably, also, there has been a certain amount of resentment against the unfortunate Pakistani immigrants.

In these circumstances, there has been an outcry against the authorities, and people who never criticized the Ministry of Health before have begun to ask whether the policy of letting all and sundry in without a vaccination certificate is wise. Some criticism has been disarmed by the statement that the five immigrants with smallpox all had valid certificates of recent vaccination, but some doubt has been cast on the authenticity of some documents produced by immigrants, and Lady Summerskill did not hesitate to say in the Lords debate that they were forgeries. In the Commons debate on the subject on January 23, there was a division of opinion on whether the Ministry had been slow to take precautions with immigrants from Pakistan, the opposition asserting that the authorities had known of the Karachi epidemic long before they began to demand vaccination certificates or compulsory vaccination on arrival or quarantine. As to the English end of the situation, there is no intention of reintroducing compulsory vaccination with its attendant headaches of dealing with conscientious objectors. Incidentally, it is of interest to note the figures for complications of vaccination in England. Out of 400,000 primary vaccinations carried out in 1960, there were 15 cases of generalized vaccinia, two being fatal (both in infants under 2 months). There were eight cases of postvaccinal encephalomyelitis with three deaths in infants under one year, one death at 14 months, and another in a woman of 40 revaccinated after infant vaccination. This is in curious contrast with the situation in France, where apparently they have had only two or three such cases in ten years in spite of compulsory vaccination of all infants.

English as She is Spoke

Visitors to international congresses sometimes have trouble in determining which of the official languages a delegate is speaking. This writer recently heard a paper given by an oriental psychiatrist to which he listened hard for several minutes before being able to say with certainty that the language was English and not German. Complaints of unintelligibility of speakers using languages not their own are not uncommon, but this is only half the story. A letter in *Lancet* signed by a pathologist from Tokyo and one from Copenhagen (how did they ever get together to write it?) describes the difficulty encountered by members of the audience whose native tongue is not English, when the Anglo-Saxons give their papers. The signatories of the letter complain that speakers use slang, local laboratory abbreviations, sophisticated jokes and allusions to classical authors of their own country. This is of course only too true, and it seems to polyglots that there is more slang in the current speech of the Anglo-Saxon than in others. Indeed there is so much, and it is used so freely, that many an editor has difficulty in persuading his authors to change phrases such as "doing a PR" (which an English dictionary of abbreviations would probably render as "public relations") or "sitting on a gastric ulcer" into something that a Japanese fan with a good dictionary may be expected to understand. The writers of the letter also complain of local flavour in the pronunciation (Lancashire accents are not always intelligible in Alabama or vice versa, so what is the poor foreigner to do) and venture to suggest that speakers should take the trouble to pronounce their words properly "even if it might deprive them of the relish to speak their native version of English."

A PLAN FOR HOSPITALS

One of the black spots in the National Health Service has been the pittance spent so far on hospital construction and repair. Overseas visitors have marvelled at the good work being done in buildings which seem out of the pages of Dickens, and an overhaul of these relics is long overdue. The excuse has been of course that such government money as was available for building should go to worthier objects such as schools, though one economist has pointed out that the return from a monetary investment is much less with a school than a hospital, for the latter is used 24 hours a day and 365 days in the year. However, better late than never, and the Minister of Health has now produced a ten-year plan for construction of new hospitals and remodelling of old ones. The new plan is based on the philosophy that it is better to have fewer and larger hospitals farther apart than a lot of small, less comprehensive ones in smaller centres of population. It is argued that the greater range of services which the large district general hospital can afford will compensate for the longer distances which relatives will have to travel to visit the sick. These new district general hospitals will provide treatment and diagnostic facilities for inpatients and outpatients, and include a short-stay psychiatric unit, a maternity unit, a geriatric unit and facilities for isolation of infectious cases. Some specialties will be confined to a few of these hospitals; these include radiotherapy, plastic surgery and neurosurgery. The general idea is to have a hospital of 600-800 beds for a population of about 100,000-150,000. There is some vague talk about establishing peripheral clinics or diagnostic centres for local consultation, and some existing local hospitals could be used for this purpose. Presumably this plan will further limit the possibility of the general practitioner getting a foothold in the hospital, though he may make his contacts with specialists in the peripheral centres. There is however some mention of "general practitioner beds" in district hospitals, though this is again very nebulous.

In London, some old favourites will be rebuilt, in some instances at other sites. For example, Charing Cross Hospital is to move from the Strand to Fulham, and the Royal Free from Gray's Inn Road to Hampstead, while the urogenital hospitals of St. Paul and St. Peter go to Chelsea, and St. George's from Hyde Park to Tooting. About 750 existing hospitals will go out of business by 1971, and a further 500 are doomed later. However, there's many a slip, etc., and firm dates for work are not given, nor can the present Minister commit his successors for the years to come. Commenting on the scheme, the *Lancet* and *B.M.J.* take opposite stands on the question of central direction of the whole program. *The Lancet* thinks that without a firm direction from the centre no such integrated program would be possible and welcomes the possibility that odium for the disappearance of local hospitals may fall on the distant capital rather than on local characters, while the *B.M.J.* remarks that regional boards and boards of governors have had to fit their designs into a central plan, and suggests that maybe the men on the spot know better. Lastly, and this is the real crux of the matter, it is all very well to build hospitals but what about staffing them, says the *B.M.J.*

S. S. B. GILDER

MEDICAL NEWS IN BRIEF

PENICILLIN THERAPY OF SYPHILIS

Hellerström and Skog studied the outcome of penicillin therapy in 231 cases of syphilis, which included all stages, in material from three major hospitals in Stockholm (WHO/VDT/288, 1961). The standard treatment for the early stages of the disease was 10,200,000 units of procaine penicillin given over a 17-day period. Larger amounts were administered for the later stages. The observation period varied from three to 12 years. The results of this standard treatment, which is generally used in Sweden, were good.

The clinical results in 91 cases of primary and secondary syphilis were entirely satisfactory, and no relapse occurred. Seventy-four of these were followed up serologically. In 34 primary cases among them, all became seronegative, while 98.5% of the remaining 40 secondary cases were seronegative by the end of the examination period; one serological relapse occurred in an inadequately treated patient. Among 79 patients with latent syphilis, no clinical or serological progression was observed. A total of 38 cases of neurosyphilis were treated. Fifteen of 23 patients (65%) with asymptomatic neurosyphilis were considered cured, while the remaining patients were improving at the last examination. All three cases of meningovascular syphilis improved after therapy. Among five patients with general paresis who were given malaria therapy and penicillin, three improved significantly; in two others the condition was aggravated and one patient died. One of the patients with primary optic atrophy, one with eighth-nerve deafness and one of three patients with tabes showed clinical improvement. One of six patients with cardiovascular syphilis died from myocardial infarction, while the condition was unchanged in five. Four cases of gumma healed clinically. No clinical or serological progression was observed in 13 cases of congenital syphilis. Allergic reaction to the penicillin preparations was observed in 3% of patients.

COPPER METABOLISM IN WILSON'S DISEASE, LAENNEC'S CIRRHOSIS AND HEMOCHROMATOSIS

A study, consisting of the intravenous administration of a dose of short-lived radiocopper (Cu^{64}) followed by periodic analyses of the radioactivity of the blood, urine and feces, along with *in vivo* measurements of radioactivity, was carried out on five patients with Wilson's disease, two with Laennec's cirrhosis, two with hemochromatosis, and on seven normal adults. In addition, two of the patients with Wilson's disease and four of the controls were given radiocopper orally, and one patient with Wilson's disease was given a large transfusion of normal plasma.

Maytum *et al.* (*Proc. Mayo Clin.*, 36: 641, 1961) report that the patients with Wilson's disease showed little or no ceruloplasmin Cu^{64} within 48 hours of the intravenous administration of Cu^{64}. This was demonstrated by starch electrophoresis, by ammonium sulfate precipitation, and indirectly by the lack of a rising level of Cu^{64} in the serum.

There was little Cu^{64} in the urine of patients who did not have Wilson's disease, whether the Cu^{64} was